POTENTIAL FOR COLLABORATION AMONG STATE AGENCIES

TO ENSURE QUALITY OF CARE IN

HEALTH MAINTENANCE ORGANIZATIONS

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For the

National Academy for State Health Policy Project

"STATE INTERAGENCY COLLABORATION: ASSURING QUALITY CARE

FOR

MOTHERS AND CHILDREN IN MEDICAID RISK-BASED MANAGED CARE"

May 15, 1997

Acknowledgments

The Virginia Department of Health, the Bureau of Insurance of the Virginia State Corporation Commission, and the Virginia Department of Medical Assistance Services wish to express gratitude to the National Academy for State Health Policy and the David and Lucile Packard Foundation for the financial and technical assistance to implement this important project. These agencies of the Commonwealth of Virginia are also very appreciative of the recognition this grant award bestows on the importance of interagency collaboration for quality oversight of managed care. Last, we would like to extend our thanks and appreciation to Jane Horvath with the National Academy for her insight and vision, and her considerable efforts toward the success of this project .

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EXECUTIVE SUMMARY

In 1997, the Virginia General Assembly passed legislation that changed the State Health Commissioner's discretionary examination of HMO quality to a mandatory responsibility; the legislation further required that the Virginia Department of Health undertake and publish a study of quality of care and consumer protection mechanisms currently in place for Virginians in HMOs. House Bill 2785 further stipulated that the study address coordination of the regulatory roles of the Bureau of Insurance and the Health Department with respect to HMO quality of care in a manner that would minimize overlapping of authority and duplication of authority.

The grant from the National Academy for State Health Policy was a fortuitous advantage to the Commonwealth of Virginia at a time when much attention was directed to the appropriate role of state agencies in regulating managed care. This paper examines the similarities in managed care regulatory functions of three agencies of the Commonwealth of Virginia, the State Corporation Commission, the Department of Health, and Department for Medical Assistance Services. The focus of the paper is overlapping authority for quality improvement, grievance systems, and data systems.

The paper identifies the statutory and regulatory authority for each agency and compares the systems in place for oversight. Recommendations are made for collaboration on HMO site visits and data sharing for quality improvement.

Although similar oversight functions were identified, they were not found to be redundant. The three state agencies examine and monitor HMO quality provisions in a like and parallel manner, but the Medicaid context is specific to a frail population with unique needs. Accountability for quality of healthcare is a serious responsibility incumbent on all three agencies, but the Department of Medical Assistance is accountable also to the Federal government and to the State. They are purchaser as well as regulator.

The potential for collaborative efforts to improve quality are significant, particularly with respect to data sharing. It is in this effort that the greatest possibilities exist for improving quality of care in Virginia managed care organizations.

NATIONAL ACADEMY FOR STATE HEALTH POLICY

STATE INTERAGENCY COLLABORATION

INTRODUCTION AND BACKGROUND

The National Academy for State Health Policy's grant award to the Commonwealth of Virginia came at a significant time for health policy makers in Virginia. In tandem with the grant application process, the Virginia Department of Health (VDH) was making internal changes in anticipation of the passage of a bill in the 1997 Virginia General Assembly that would change the role of the State Commissioner of Health from discretionary to mandatory with respect to the oversight of quality of care in Health Maintenance Organizations.

The bill, House Bill 2785, passed the General Assembly, was signed by the Governor on March 21, 1997, and will become effective July 1, 1997.

Although the *Code of Virginia* already contained provisions for consultation between the Commissioner of the State Corporation Commission's Bureau of Insurance and the Commissioner of Health concerning health maintenance organizations, the change effected by the passage of HB 2785 requires the Health Commissioner to "examine the quality of health care services of any health maintenance organization licensed in Virginia and the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of [the] Commonwealth."

The bill further specifies the role of the Commissioner of Health in stipulating that the Commissioner examine the complaint systems and complaint reports of HMOs.

With respect to the NASHP grant, of particular interest is the provision in the bill that requires that the Commissioner of Health "coordinate the activities undertaken pursuant to this [bill] with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation."

The State Corporation Commission (SCC) has the primary responsibility for regulation of HMOs in the Commonwealth.. The SCC licenses HMOs and their agents; oversees their financial condition to ensure solvency; reviews complaints from HMO enrollees that do not involve quality of care; approves the forms issued to provide coverage to groups and enrollees; and conducts market conduct examinations. As HMO enrollment has grown in the Commonwealth, there has been an increased emphasis on quality of care issues, which the SCC believes to outside its regulatory scope. Consequently, the SCC's Bureau of Insurance (BOI) signed a memorandum of agreement with VDH to collaborate on quality oversight of HMO plans. The MOA spells out

the coordinated roles of BOI and VDH and requires that VDH review HMO networks, grievance procedures, quality assurance programs and utilization review programs as part of HMO licensure review. The MOA further provides for VDH administrative and on-site review of HMOs in response to consumer and provider complaints about quality of care.

Thus, the Virginia State Corporation Commission and the Virginia Department of Health have formalized a collaborative and coordinated process for oversight of HMO's.

Virginia's Medicaid agency, the Department of Medical Assistance Services (DMAS), began contracting with HMOs in 1995 and implemented a mandatory HMO enrollment program in January of 1996 in the urban eastern region of the Commonwealth . The agency expects to have mandatory HMO programs in place in other urban areas of the state in the next two years.

DMAS' regulatory authority for oversight of Medicaid HMO's is found in federal and state statutes and regulations and in the HMO contract. DMAS is currently working with a consultant to develop a new HMO contract and RFP for their mandatory HMO program. Although the regulations and statutes contain provisions for quality assurance and encounter data, most of the detailed requirements for data and Q.A. are found in the HMO contract. On the other hand, federal and state regulations explicitly provide for a client appeals process independent of the HMO's grievance and appeals process, and the HMO contract, although it contains requirements for complaints and grievance systems, also requires that HMOs notify Medicaid enrollees of their right to appeal directly to the state.

Prior to the grant award by the National Academy, DMAS and VDH had held discussions about the possibility of collaboration on quality assessment of managed care. Both agencies felt the need for collaboration in order to avoid over-regulation and duplication, particularly with respect to NCQA accreditation, which DMAS requires of its contracted HMOs. Although DMAS had a managed care QA program in place that was broad in scope, the agency had not conducted on-site visits to HMOs, and collaboration on this issue was the focus of discussions between the two agencies. Additionally, DMAS has consulted with BOI concerning licensure and solvency from the outset of their HMO contracting and the two agencies intend to strengthen their collaboration concerning HMO financial reporting and solvency.

Another important area of collaboration between VDH and DMAS is underway with the development of the new HMO contract and Request for Proposal. VDH is recommending changes to the contract that address public health concerns such as communicable disease reporting, preventive care for mothers and children, and children with special health care needs.

While interagency collaboration for quality oversight of managed care has already begun in Virginia, the NASHP grant has clarified the agenda and invested the collaborative process with increased validity and heightened visibility.

AREAS FOR COLLABORATION

The checklists provided by the National Academy serve as a focused identification of areas for collaboration, and the modules as a useful classification. The three agencies -- Bureau of Insurance, Department of Health and Department of Medical Assistance Services-- have agreed to pursue discussions on collaborative oversight activities in three important aspects of quality improvement: on-site visits to HMOs; complaints and grievances; and data sharing.

This paper presents a discussion of the overlapping regulatory authority in these areas and identification of potential collaborative approaches.

QUALITY IMPROVEMENT

I. Medicaid Managed Care Quality Assurance Program

A. Federal and State Statutes and Regulations

With regard to Medicaid HMO quality improvement programs, the Code of Federal Regulations (CFR) requires that the HMO contract contain provisions specifying that the Medicaid agency evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract; and that the contract require the HMO's participation in an annual independent external review of the quality of services furnished under the contract. (42 CFR 434.6(a)(5), 1902(a)(30)(C) of the Social Security Act.) 42 CFR 434.34 additionally requires that the HMO contract provide for "an internal quality assurance system that is consistent with the utilization control requirement of part 456 of CFR; provides for review by appropriate health professionals of the procedures followed in providing health services; provides for systematic data collection of performance and patient results; provides for interpretation of this data to the practitioners; and provides for making needed changes." CFR at 434.53 assigns to the Medicaid agency the responsibility of periodic medical audits, at least annually, and the collection of data that includes reasons for enrollment and termination and use of services.

The state Medicaid Manual and Section 1902 (a) (30) © of the Social Security Act specify the types of entities eligible to perform external review.

State regulations developed for Medallion II, DMAS' mandatory HMO program, contain a number of provisions for quality improvement. 12 VAC 30-120-380 and 12 VAC 30-120-400 address encounter data; HEDIS reporting; standards for quality; readability of client materials; appointment availability for sick and routine care; network adequacy including Part H providers; qualification of utilization review staff; case management for people with complex health care needs; disclosure of physician incentives; and quality monitoring of utilization patterns.

B. Penalties

DMAS' authority to sanction HMOs is found at 12 VAC 30-120-410: "if DMAS determines that an HMO is not in compliance with state or federal laws, regulations...or their Medallion II contract, DMAS may impose sanctions on the HMO. The sanctions may include, but are not limited to:

1. Limiting enrollments...
2. Freezing DMAS assignment of recipients to the HMO
3. Limiting HMO enrollment to specific areas
4. Denying, withholding, or retracting payments to the HMO

5. Terminating the HMO's Medallion II contract
6. Developing procedures with which the HMO must comply to eliminate specific sanctions."

The HMO contract contains provisions for termination of the contract as do the regulations; at 12 VAC 30-120-410.B. is a provision for immediate termination in the event that DMAS determines that the HMO poses a threat to the life or safety of a recipient. HMOs have the right to appeal any adverse action taken by DMAS, although DMAS may terminate the contract with or without cause upon thirty days written notice and such action is not subject to appeal..

C. Agency Quality Assurance Plan for Managed Care

Virginia's Department of Medical Assistance Services has developed a managed care QA program that is very broad in scope. DMAS develops an annual Quality Assurance Plan for Medicaid Managed Care and has an internal Quality Review Committee that meets at least quarterly. There is also an HMO Oversight Group that includes representatives from other state agencies, and from professional organizations and advocacy groups. Additionally, the Case Managers Group holds quarterly meetings that are attended by providers, HMO case managers, local health departments, local Community Services Boards and other interested parties in the seven cities in the Tidewater area of the Commonwealth where mandatory HMO enrollment has been implemented.

DMAS' QA studies have focused on immunizations, prenatal care, hypertension, asthma, and a client survey that compares responses from clients in fee-for-service, primary care case management, and HMOs. The survey addresses perception of health status and satisfaction with quality and access to care and is being administered for the third time.

As part of DMAS' federally mandated independent review of the quality, the HMO contract requires immediate reporting by the HMOs of "sentinel events" -- outcomes of care that could possibly signify underutilization of care--and DMAS' external quality review organization (EQRO) performs a medical audit of the care received in these instances. Sentinel events include a death; a readmission to the hospital within a week of discharge from an inpatient stay or an Emergency Room visit; an unscheduled return to the Operating Room; an admission to the hospital following ambulatory surgery; and certain post-operative infections.

Other areas of quality review outlined in the DMAS QA plan include monitoring NCQA accreditation status; HEDIS-type audits of availability of targeted physician specialties; assessing and improving the reliability and validity of HMO encounter data; a survey addressing reasons for enrollment and disenrollment in HMOs; and efforts aimed at the Aged, Blind and Disabled Medicaid clients in mandatory HMO programs.

The DMAS QA plan has HMO on-site visits included as an objective, and although the agency has not undertaken this type of review to date, it is anticipated that provision for regular and

recurring on-site visits will be included int he revised HMO contract..

D. DMAS HMO Contract

Because the DMAS contract and Request for Proposals are currently being revised, comment can only be made on the current contracts for both the mandatory HMO program and the agency's optional HMO program; however, it is anticipated that current contract provisions for quality improvement will be augmented rather than scaled down in the new contract.

The current contract requires that HMOs be accredited or seeking accreditation by the National Committee for Quality Assurance. All contractors are required to have a quality improvement program and plan and to participate in DMAS' QI program. The contract contains specifications for the HMO QI plan and program including goals and objectives; focused studies; organizational structure; criteria and standards for quality performance; documentation of QI activities; credentialling standards; medical necessity criteria; grievance systems and medical records. The contract further contains extensive reporting requirements on quality of care issues including child and maternal health statistics, network changes, hospital statistics, complaints and grievances, and utilization. The contract also requires detailed encounter data for all health care services.

II. Virginia Department of Health Quality Assurance Program

A. State Statutes and Regulations

Chapter 43 of Title 38.2 of the *Code of Virginia* confers permissive authority on the State HealthCommissioner to examine the quality improvement plans and grievance systems of HMOs. This law has been in effect since the early 1980's; and only recently has the Commissioner exercised this authority.

Chapter 43 contains the provisions for licensure and regulation of HMOs by the Bureau of Insurance. Much of the statutory language in this chapter is repeated in the HMO regulations in the Virginia Administrative Code (VAC). The Bureau of Insurance has licensed and examined HMOs since the first HMO was established in Virginia in 1982.

With the advent of Medicaid managed care contracting and the rapid increase in commercial managed care enrollment, the Virginia General Assembly has responded to various and diverse constituencies' concerns about managed care and consumer protection with the introduction and passage of significant legislation. The 1996 session of the General Assembly was notable for the number of bills introduced addressing managed care issues, one of which was a Senate Resolution (SJR 67) that required a study of the various state agencies involved in managed care oversight. At the same time, a newly appointed State Health Commissioner signed a Memorandum of Agreement with the State Corporation Commission's Bureau of Insurance to

assume responsibility for the quality of care in HMO's.

The 1997 General Assembly passed legislation that changed the State Health Commissioner's discretionary authority to examine HMO quality of care and grievance systems to a mandatory responsibility; the legislation further required that the Virginia Department of Health undertake an ambitious study of the role of the Commonwealth in monitoring and improving the quality of care in managed care plans, especially the quality of care and consumer protection mechanisms currently in place for Virginians in HMOs.

In anticipation of this legislation, and as a result of the formal Memorandum of Agreement between the Bureau of Insurance and the Department of Health, the VDH Office of Health Facilities Regulation changed its name to the Center for Quality Health Care Services and Consumer Protection to acknowledge the inclusion of managed care entities with hospitals, nursing homes, and other facilities licensed and examined by that division. More importantly, the name change signaled a conscious effort by the Health Department to move away from the facility approach to regulating these entities and to highlighting the division's principal mission of assuring quality of care for Virginians.

The MOA delegates to VDH specific requirements for quality oversight: adequacy of HMO networks; access to care; grievance procedures; quality assurance and utilization review programs; review of quality of care complaints; and on-site examinations. The MOA further confers on VDH the broad responsibility for "quality assurance issues relating to Health Maintenance Organizations". The MOA allows the Health Department to gain from the experience of the Bureau of Insurance in regulating HMOs and to operate under its legal and regulatory structure until the General Assembly can direct the promulgation of regulations specific to the Health Department. Thus the provisions in the statutes and regulations addressing quality of care apply to the Virginia Department of Health, as follows:

1. HMO QI Plan and System

Neither the statutes nor the regulations contain explicit requirements for an HMO's QI plan, structure, or functions. The only requirements for QI *per se* are at 14 VAC 5-210-50: "Each application for a health maintenance organization shall set forth or be accompanied by... [a]description of the procedures and programs established by the HMO to (I) assure both availability and accessibility of adequate personnel and facilities, and (ii) assess the quality of health care services provided."

This regulation is identical to Section 38.2-4301(B)(11) of the *Code.* Sec. 38.2-4307 of the *Code* requires that HMOs submit annual statements to the Commissioner of the State Corporation Commission and the State Health Commissioner that include financial statements, material changes to the information submitted pursuant to HMO's licensure; enrollment numbers; and "any other information relating to the performance and utilization of the HMO required by the Commission after consultation with the State Health Commissioner to carry out the

Commission's duties [of HMO oversight]."

This section appears to give the State Health Commissioner and the SCC Commissioner broad powers to seek specific documents relating to quality of care and utilization. Similarly, 14 VAC 5-210-50 (3)(p) confers broad authority on the BOI to require "any and all such other information as the Commission may require to make the determinations required pursuant to [licensure]." This is mirrored in the *Code*, 38.2-4306(D): "The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing [for licensure or renewal] made under this section."

The *Code* grants the State Health Commissioner further broad authority at 38.2-4315(B): "The State Commissioner may examine the quality of health care services of any health maintenance organization or providers with whom the organization has contracts, agreements, or other arrangements according to its health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth." With the passage of HB 2785, the “may” in this section was changed to “shall” effectively changing the discretionary authority to mandatory, and this statute was moved to Title 32.1 of the *Code,* which contains the health laws of the Commonwealth.

At 38.2-1317, the State Corporation Commission is given broad authority to make examinations: "Whenever the Commission considers it expedient for the protection of the interests of the people of this Commonwealth, it may make or direct to be made an examination into the affairs of any [company] licensed to transact any insurance business in this Commonwealth...". At 38.2-4316, the Code provides for suspension or revocation of an HMO’s license of the Health Commissioner certifies to the State Corporation Commissioner that the HMO is unable to fulfill its obligations to furnish quality health care services. 38.2-1317.C. requires that insurance companies make available to BOI examiners during on-site examinations "books, records, files, securities, accounts, papers, documents, and any or all computer or other recordings relating to the...business and affairs of the company being examined...".

The broad authority extended to the State Health Commissioner to "examine the quality of health care services of any HMO...as often as considered necessary for the protection of the interests of the people..." presumably can be applied to the specific reviews of medical records of subcontracted providers; QI plans, and execution of those plans; clinical studies; networks and UR programs. The Center for Quality Health Care and Consumer Protection, in fact, reviews all of these during on-site examinations, and could examine them as needed in the interval between mandated examinations.

2. Medical Records

Chapter 54 of Title 38.2 of the *Code* addresses utilization review (UR) standards and appeals. In this chapter, there is a requirement that HMOs adopt a UR plan that includes" policies and procedures designed to ensure confidentiality of patient-specific medical records and

information..."

3. Travel and Waiting Time Standards

While there are no explicit codified travel and waiting time standards, 14 VAC 5-210-90.A. states : "Each HMO shall establish and maintain adequate arrangements to assure both availability and accessibility of adequate personnel and facilities providing health care services including: (a) reasonable hours of operation and after-hours emergency health care; (b) reasonable proximity to enrollees within the service area so as not to result in unreasonable barriers to accessibility; © sufficient personnel, including health professionals, administrators, and support staff, to reasonably assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees..."

4. Consumer Involvement Required

Section 38.2-4304.B. of the Code requires that the governing body of any HMO "establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (I) the establishment of advisory panels, (ii) the use of advisory referenda on major policy decisions, or (iii) the use of other mechanisms."

VAC 5-210-50 (B)(3)(o) requires that an HMO's application for licensure include " a description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in Subsection B of 38.2-4304 of the *Code*."

(Both VDH and BOI have indicated publicly that requiring enrollee representation on the governing board of HMOs to strengthen the provisions of the above statute and regulation is a reasonable policy.

5. Utilization Review Program

Chapter 54 of Section 38.2 applies to any person or entity performing utilization review internally with the exception of Medicare, Medicaid, and ERISA programs, and so would apply to all managed care organizations licensed in Virginia that do not subcontract with a Utilization Review agent outside of the plan. 38.2-5403 requires that each HMO or managed care organization adopt a utilization review plan and stipulates the requirements for the UR plan.

Section 38.2-5402 of the Code requires that each HMO "shall establish standards and criteria to be applied in utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various American medical specialties. Such standards shall be objective, clinically valid, and compatible with established principles of health care...[The HMO] shall make available to any provider...the standards and criteria established in accordance with this section except as prohibited in accordance with copyright laws."

Additionally, 38.2-5409 of the *Code* requires that every HMO "shall maintain...in writing...records of review procedures [and] the criteria used...to make decisions..."

Section 38.2-5402.E. requires HMOs to have "review staff who are properly qualified, trained and supervised, and supported by a physician advisor, to carry out [the HMO's] review determinations."

Section 38.2-5409 requires that written records be kept of "the number and type of adverse decisions, and reconsiderations; the number and outcome of final adverse decisions and appeals... including a separate record for expedited appeals..."

Section 38.2-5402.C. requires that HMOs have a process for reconsideration of adverse decisions and an appeals process. 38.2-5402.F. requires HMOs to notify covered persons of the review process, and to notify providers of the review process upon written request. Section 38.2-5407 of the *Code*, "Reconsideration of adverse decision," states that "any reconsideration of an adverse decision shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel."

Section 38.2-5402.G. of the *Code* requires HMOs to communicate UR decisions no later than two business days after receipt of all information necessary to complete the review. Section 38.2-5405 addresses authorizations for emergency health care. Section 38.2-5408 requires HMOs to "establish an appeals process, including a process for expedited appeals, to consider any final adverse decision that is appealed..."

It should be noted that most of the Code sections addressing Utilization Review requirements end with a section that states that the Commission [i.e., BOI] has no jurisdiction to adjudicate controversies arising out of that section.

6. Standards for HMO Reporting

An Annual Statement is required of all licensed HMOs that includes financial statements, enrollment numbers, and changes in any of the information submitted for licensure: provider contracts, Evidences of Coverage; QI procedures and programs; enrollee participation policy; financial statements; group contract forms, articles of incorporation, etc. (*Code*, 38.2-4307). The Annual Statement must be filed with the Commissioner of Insurance, and a copy sent to the Commissioner of Health. 38.2-4307 of the *Code* gives the State Corporation Commission the authority to request, in the annual statement, "any other information relating to the performance and utilization of the HMO..." Separate code sections address annual complaint reporting (38.2-4308.B) and quarterly provider network reporting (38.2-4311). Section 38.2-4307.1 gives BOI broad authority to request additional reports in addition to the annual statement "considered necessary to secure complete information concerning the condition, solvency, experience, transactions or affairs of the HMO."

7. Aggregate Data Requirements

A separate *Code* section (38.2-4308) stipulates requirements for an HMO's complaint system. Included in this section is the requirement for aggregated complaint data, in a format prescribed by the SCC, an annual report that includes 1) a description of the complaint system procedures; 2) the total number of complaints handled through the system; 3) a compilation of causes for the complaints filed; and 4) the number, amount and disposition of malpractice claims settled or adjudicated during the year by the HMO and any of its providers.

Regarding aggregated data on utilization review complaints and appeals, 38.2-5409 of the Code requires that HMOs keep records "at a location accessible to employees of the [Bureau of Insurance], records of review procedures; ...complaints received; ... the number and type of adverse decisions and reconsiderations; the number and outcome of final adverse decisions and appeals...including a separate record for expedited appeals..." So, while this UR data is not required to be reported, it is required to be kept and aggregated for the purpose of inspections. (*Code*, 38.2-5409).

B. Penalties

The *Code* provides for the Health Department to suspend or revoke an HMO's license if the HMO is providing substandard quality of care at Section 38.2-4316 if "the State Health Commissioner certifies to the Commissioner [of the State Corporation Commission] that the health maintenance organization is unable to fulfill its obligations to furnish quality health care services...consistent with prevailing medical care standards and practices in the Commonwealth."

Under Title 38.2 of the *Code***,** section 218 provides for penalties and restitution payments any violation of any provisions of the title or of any regulations issued pursuant to Title 38.2. Each violation may carry a penalty of up to $5000. Restitution may be required in the amount of direct actual financial loss for excessive rate charges, for discriminatory premiums, and for failure to pay amounts specified by insurance contracts. Subsequent sections address injunctions and enforcement of penalties.

Section 38.2-4316 sets forth the conditions for the suspension or revocation of an HMO license including failure to provide basic health care services; failure to implement a mechanism for providing enrollees an opportunity to participate in matters of policy and operations; failure to implement the prescribed complaint system; deceptive advertising; or failure to substantially comply with the provisions of Chapter 43 of the insurance laws.

C. Virginia Department of Health QI Program

The VDH QI program is in the early stages of development and currently is circumscribed by the MOA with the Bureau of Insurance and the state statutes and regulations addressing quality and

grievances. As previously stated, these laws confer broad authority that presumably could be used to expand the program "for the protection of the interests of the people of the Commonwealth" .

Currently, the agency's program focus is three-fold: certification for HMO licensure, site-visits in conjunction with the Bureau of Insurance market conduct examinations, and complaint investigation.

Through the MOA, VDH is charged with the responsibility of reviewing and certifying HMO quality assurance and utilization review programs as part of initial licensure. They also must review the HMO provider networks to assure the appropriate number and specialty mix of providers.

VDH has conducted four on-site visits to HMOs with the Bureau of Insurance since the execution of the Memorandum of Agreement, including a visit to an HMO that enrolls commercial and Medicaid members. The Bureau conducts market conduct examinations year round so that every licensed HMO is visited every four years. When VDH goes on-site to the HMOs they examine the grievance and complaint system, complaint logs, and documentation of actual complaints and grievances. The quality assurance program is reviewed and the HMO must produce evidence of plan execution. VDH examines data on services for emergency, preventive, inpatient, outpatient, and tertiary care services in a medical record review. Files of primary care physicians are examined and audited for preventive care such as screening for cholesterol, breast cancer, and diabetes; and childhood immunizations. Document review is intensive and examines organizational charts; minutes of QA committees and subcommittees; member surveys; member education materials; and credentialling files.

Any accreditation reports are reviewed as are the HMO's process and results of monitoring and evaluating performance, including enrollment and disenrollment statistics. VDH reviews clinical studies performed and data on provider availability.

The third area of quality assessment focus for the Department of Health is member complaints and grievances, addressed in a separate section of this paper.

III. Areas of Overlap and Potential for Collaboration for the Department of Medical Assistance Services, the Department of Health, and the Bureau of Insurance

While there are obvious areas of overlap among the Department of Health, the Bureau of Insurance, and the Department of Medical Assistance Services with regard to regulation of HMO quality improvement programs, collaboration for consolidation of this function is not necessarily warranted in all areas. Both DMAS and VDH approve HMO QI plans. The Health Department's interest is in ensuring that the plan is sufficiently broad in scope and specific in detail to provide a structure and process for quality improvement, regardless of the income of the

person covered. DMAS has a similar interest, but a different focus: the provisions the HMO is making for quality improvement for Medicaid recipients, for whom oversight is a function dictated by the frailties inherent in the population. DMAS performs a thorough review of contract proposals from HMOs and looks very closely at quality mechanisms in place for pregnant women, children, and people with disabilities.

Most HMOs interested in Medicaid contracts will offer a Medicaid plan that is a separate product from their commercial business. Provider networks may be very different from the commercial product, and may be reimbursed at the Medicaid rate rather than a more competitive rate. Certainly, covered services are very different, with the Medicaid product offering all services covered by the State Plan for Medical Assistance, and any additional services the HMO wants to offer, while a commercial product is defined by state statutes and employer preferences.

It is not recommended that the state agencies consolidate or collaborate on the review and approval of HMO QI plans at this time, except perhaps to share the results of their reviews. DMAS has recently contracted with a consultant to rewrite the HMO contract and request for proposal. The consultant will also review the proposals submitted by HMOs interested in contracting with DMAS for the mandatory program which will soon be expanded into Northern Virginia and Central Virginia. It is anticipated that HMO contract proposals will receive even greater scrutiny than was previously the case when DMAS performed these functions internally. It is also anticipated that the new contract and RFP will contain more rigorous quality requirements tailored to the Medicaid population.

There are, however, several areas in which collaboration for coordination and consolidation of oversight functions may be appropriate, as follows:

1. Site Visits.

DMAS has not performed on-site visits to HMOs to date. The Department of Health has an entire division staffed with clinicians with specialized expertise in facility regulation and licensure, the Center for Quality Health Care Services and Consumer Protection. The mandates of HB 2785 require that the Bureau of Insurance and the Department of Health "coordinate the activities undertaken pursuant to [quality review of HMOs] to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation." Clearly, on-site visits are a regulatory burden for HMOs, but as BOI and VDH have devised a collaborative process for site visits, it is appropriate for DMAS to explore the feasibility of on-site visits to HMOs in conjunction with the other two agencies.

The aim would be to minimize the disruption of on-site inspections and to consolidate specific aspects of the review. It would be appropriate for VDH and DMAS to consider the intervals of on-site visits -- VDH plans to visit HMOs every four years, and is considering more frequent visits, while DMAS might want to visit more frequently. Whether or not the two agencies are participating in every site visit, the opportunity for sharing information gleaned from on-site

visits should be explored.

2. Accreditation by the National Committee for Quality Assurance

The first directive of the study requirement contained in HB 2785 requires an examination of all quality of care mechanisms in place for HMOs including state and federal statutes and regulations and standards of the National Committee for Quality Assurance (NCQA). Legislators and policy makers are aware of the importance of NCQA accreditation but also are mindful of the burden it imposes on the industry. A key provision of HB 2785 is the admonition to minimize overlapping authority and duplication of resources among state agencies. Thus, it could be very advantageous for the departments of health, insurance, and medical assistance to collaborate on the issue of NCQA accreditation and the feasibility of deeming of certain QI functions, although this area of collaboration has not been explored.

3. Contract Development

As previously stated, the most explicit quality requirements for HMOs contracted with Virginia Medicaid are found in the contract for services, which also includes the HMO responses to the Request for Proposals (RFP). VDH began discussions with DMAS in 1996 to consider additions to the contract addressing specific public health concerns such as maternal and child health provisions and communicable disease reporting. In May of 1997, VDH met with the DMAS contractor developing the new contract and subsequently submitted written rrecommendationsfor specific changes and additions to the contract.

VDH will continue working with DMAS on the new contract, which is expected to be finished by early summer. The final contract will then become a blueprint for possibilities for further collaboration on enforcement of contract provision for quality improvement and public health concerns.

GRIEVANCE AND COMPLAINT SYSTEMS

I. Medicaid Regulations

A. Federal and State Regulations on Grievances and Appeals

Federal statutes and regulations addressing client grievances are found in Section 1902(a)(3) of the Social Security Act and in the Code of Federal Regulations at 42 CFR 431.200 et seq. The Code of Federal Regulations requires that a State Plan for Medical Assistance provide for an opportunity for a fair hearing to any person whose claim for assistance is denied, and to any person whose Medicaid services are suspended, terminated or reduced. The federal regulations contain provisions for notifying recipients of hearing procedures and their right to a hearing; for content and timing of the notice; for agency actions that require a hearing; for the conduct of hearings; and for procedural rights of the recipient. With regard to HMO enrollees, 42 CFR 434.32 requires that the HMO contract must provide for an internal grievance procedure that is approved by the Medicaid agency; that provides for prompt resolution and that assures the participation of individuals with the authority to require corrective action. 42 CFR 434.63 mandates that the Medicaid agency ensure proper implementation of the HMO contractor's grievance procedures.

State regulations for Medicaid client appeals and grievances are found at 12 VAC 30-110, Part I. These regulations reiterate and expand the requirements found in CFR and contain specific provisions for client protections with regard to utilization review decisions: 12 VAC 30-110-100 requires that services not be terminated or reduced if a recipient files an appeal of the termination or reduction within a specified time frame; and 12 VAC 30-110-200 provides for an independent medical assessment when a hearing officer determines that medical issues are involved in the client's appeal. 12 VAC 30-110-220 through 12 VAC 30-110-370 address the grievance hearing with provisions for scheduling, notification, location, client access to records, evidence, and appeal to the state courts.

The regulations promulgated for the inauguration of DMAS' Medallion II program contain more specific provisions for UR denials; these regulations found at 12 VAC 30-120-420 cite 12 VAC 30-110 and also require compliance with BOI regulations pertaining to commercial HMOs at 14 VAC 5-210-70(H)(4). 12 VAC 30-120-420 further prescribes written notices and materials advising clients of their rights to appeal; requirements for informal and formal (written) grievances; records and reporting of grievances; time frames for compliance, and provision for expedited grievance decisions.

The state protections for HMO utilization review decisions are significant. Chapter 54 of Title

38.2 of the *Code of Virginia* contains the provisions for UR appeals for commercial HMO enrollees, and explicitly exempts Medicaid HMO enrollees from its mandates.

B. Contract Requirements for Grievances and Appeals

Further protection for Medicaid clients with respect to grievances and appeals are found in the HMO contract where specifics again are articulated regarding client notification; timeframes; informal and written grievances; record-keeping and reporting for both formal and informal grievances; and expedited appeals. Article VII.A.9. provides for expedited grievance decisions, within 48 hours "in case of medical emergencies". The contract also requires that HMO contractors notify the client in writing of an adverse action at the time of the action, and that the client be notified of the right to appeal to the HMO and/or to appeal directly to DMAS concerning issues of "medical necessity, specialist referral or other service delivery issues".

C. Complaints

In August of 1996, the Department of Medical Assistance Services contracted with an enrollment broker for their managed care programs. The contractor is responsible for educating Tidewater clients about requirements for the mandatory HMO program, Medallion II, and informing clients in the Richmond and Northern Virginia areas about their choices: HMO or primary care case management. In addition to enrollment and education, the contractor's primary responsibility is to staff and manage an enrollee help line. All complaints are recorded and sent to DMAS on a weekly basis.

The enrollment broker, Benova Inc., classifies complaints by HMO as either a complaint about the HMO or about an HMO provider.

Although DMAS' internally staffed help lines are currently intended for non-managed care clients, occasionally complaints still come to the agency from managed care clients, either to the help line or to other staff. When this happens, the agency uses the "green form", a complaint summary form developed for managed care clients. This form classifies problems or complaints as one of the following: access to provider or service; quality of care issue; marketing; payment (provider) or payment (client); or other.

The Medicaid HMO Contract for Services also requires complaint reporting by the HMOs. HMOs are required to keep records of all formal or written complaints or grievances including the decision and nature of the decision, and these records must be kept separate from those of commercial enrollees.

The contract also requires a record-keeping system for informal grievances and complaints in the form of a log that includes a brief summary of the problem, the decision, and the nature of the decision.

Both informal and formal grievances are required to be reported quarterly by the HMOs. Because of widely disparate reporting, the agency instituted a mandatory reporting form in January of 1997 to ensure a uniform format for complaint reporting.

Complaints from all sources -- Benova, agency, and the HMOs-- are reviewed in the DMAS Division of Program Operations and in the Division of Policy Development where they are also entered into a computerized tracking system. The Appeals Division handles formal grievances and appeals made directly to the agency.

II. State Statutes and Regulations for Commercial Plans

A. Grievance and Complaint Procedures

Through the Memorandum of Agreement between the Health Department and the Bureau of Insurance, the Health Department is responsible for assessment of HMO grievance procedures for licensure. VDH also has the responsibility for on-site examination of HMO grievance procedures and examination of specific complaints pertaining to quality or access to care.

Chapter 5 of Title 38.2 of the *Code of Virginia* is entitled, "Unfair Trade Practices" . Sections 38.2-500 through 38.2-515 apply to HMOs. At 38.2-511 is a prohibition against failure to maintain a complete record of all the complaints that the insurer has received since the date of its last examination by the Bureau of Insurance. This section requires a record of the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, and the time it took to process each complaint.

This section of the Code also defines a complaint as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

State Statutes addressing HMO enrollee grievances are found in Chapter 43 of Title 38.2 of the *Code of Virginia*. Section 38.2-4301.10 requires, for HMO licensure, a description of the complaint system. Section 38.2-4308 mandates that HMOs establish a complaint system to "provide reasonable procedures for the resolution of *written* complaints." (Emphasis added). This section also mandates that the complaint system be approved by the SCC and that HMOs submit to both the State Corporation Commission and the Department of Health a complaint report that includes "a description of the procedures of the complaint system; the total number of complaints handled through the complaint system; a compilation of causes underlying the complaints filed; and the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the HMO and any of its health care providers."

Section 38.2-4316.7 provides for suspension of revocation of an HMO's license if the state determines that the HMO "has failed to implement the complaint system required by 38.2-4308 to resolve valid complaints reasonably...".

The state regulations addressing grievance procedures are found at 14 VAC 5-210-70.H. and require a grievance or complaint system that provides for prompt and effective resolution of written complaints. Resolution is required within a reasonable period of time, “not more than 180 days from the date that the complaint is registered. HMOs are required to provide complaint forms and/or written procedures to be given to enrollees who wish to register written complaints, and to provide the address and telephone to which complaints must be directed. HMOs must advise enrollees of the time limits for grievances.”

14 VAC 5-210-70.H.4. prohibits the termination of coverage for the enrollee “for any reason which is the subject of the written complaint, except where the HMO has, in good faith, made an effort to resolve the complaint and coverage is being terminated “because of failure to pay premiums; fraud or deception in the use of services or facilities; violation of the terms of the contract; failure to meet eligibility requirements under a group contract; or termination of the group contract under which the enrollee was covered.”

This section of the insurance regulations also requires procedures for resolution of grievances where there exists a specified arbitration agreement.

B. Utilization Review Appeals

Client appeals provisions are critically important with regard to HMO utilization review decisions. Whether a service is denied for pre-certification or for payment, U.R. decisions are at the heart of many controversies over managed care.

Chapter 54 of Title 38.2 specifically addresses appeals of HMO utilization review decisions. As stated previously, this chapter requires written records of "the number and type of adverse decisions, and reconsiderations; the number and outcome of final adverse decisions and appeals... including a separate record for expedited appeals..."

Section 38.2-5402.C. requires that HMOs have a process for reconsideration of adverse decisions and an appeals process. 38.2-5402.F. requires HMOs to notify covered persons of the review process, and to notify providers of the review process upon written request. Section 38.2-5407 of the *Code*, "Reconsideration of adverse decision," states that "any reconsideration of an adverse decision shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel."

C. Complaints

In the past, HMO enrollees have called the Bureau of Insurance to register complaints about HMOs. The Bureau requires a complaint to be written in order that it be investigated, and they provide consumers with a complaint form to use. The form has a note that explains that HMOs are required by law to have internal grievance procedures for members and that the grievance

procedure is contained in the HMO Evidence of Coverage. The note recommends that the consumer take advantage of the HMO's grievance process before filing the complaint with the Bureau.

One of the most valuable provisions of the Memorandum of Agreement between the Bureau and the Health Department is the ability of the two agencies to collaborate on consumer complaints. BOI has staffed a consumer toll-free telephone line for people with any kind of insurance problem for a number of years. They will continue to staff the consumer hotline, only now they will refer all complaints that concern quality of care or access to care to the VDH Office of Quality Health Services and Consumer Protections.

The two agencies have met to resolve technical issues concerning the consumer hotline and VDH has developed screening criteria to identify the types of problems that BOI should refer to VDH. Quality of care complaints are classified as problems with either access to healthcare services, utilization management, or practitioner/providers. The screening criteria are fairly detailed, and the Bureau of Insurance is working on adapting their information systems in order to record and track complaints according to this classification.

The consumer toll-fee telephone line is an important quality mechanism and is supported by the on-site investigation of particular complaints when they occur and during market conduct examination visits to HMOs.

III. Areas of Overlap and Potential for Collaboration

A. Areas of Overlap

1. Appeals Procedures

Federal and state provisions are in place for Medicaid clients who wish to grieve an action of an HMO, and provide for a final appeal to the state courts. Commercial HMO enrollees may also appeal to the state courts in a civil action against an HMO. The difference is that Medicaid clients have recourse to appeal to a Medicaid hearing officer, whereas commercial clients, after exhausting the HMO grievance procedure, have only the courts as a possible arbiter. However, it should be assumed that the issues of concern to most consumers will fall under the provisions in Chapter 54 of Title 38.2 of the Code of Virginia since this chapter addresses utilization review issues specifically. And while this chapter does provide for reconsideration of adverse decisions, for appeal of a final adverse decision, for expedited appeals, and for review by a peer of the provider against whose request the UR decision was made, the section specifically states that the appeals process does not apply to decisions rendered on the basis that the benefit or service in question is not covered by the HMO. This chapter also contains language emphasizing that the State Corporation Commission has "no jurisdiction to adjudicate controversies arising out of this section." Thus, a commercial enrollee's last resort would be to the state courts.

2. Record Keeping

There is one statute that applies to both commercial and Medicaid HMOs, Section 38.2-511 of the *Code*. As stated previously, this statute requires the retention of complaint records since the time of the last examination by BOI or for three years, whichever is the more recent time period. This section also defines a complaint as a written communication expressing a grievance.

3. Approval of Grievance Procedures

Although VDH has the authority, through the MOA with BOI, to approve grievance procedures at initial HMO licensure, and to review any changes to the procedure on an annual basis, DMAS will likely wish to continue to conduct their own review, particularly in order to examine specific Medicaid provisions for grievance procedures, such as the requirement that clients be notified of their right to appeal directly to DMAS, and the requirement that all written materials be appropriate to the literacy level of the clients.

B. Potential for Collaboration

1. Complaint Data

Clearly, the greatest potential for collaboration would be the sharing of the results of complaint investigations that reveal real cause for concern or quality problems. Medicaid HMOs are a subset of all the HMOs licensed in the Commonwealth, and the Department of Health and the Bureau of Insurance have considerable regulatory authority with respect to complaints brought be consumers. Although Medicaid business is generally a separate product line for HMOs, the public and commercial products share a number of functions including provider networks (to some degree), UR staff, and quality improvement processes. A problem discovered, whether the consumer is Medicaid or commercial, may have significant relevance to the HMO as a whole, and it would be in the interest of the Commonwealth that state agencies charged with oversight and monitoring of complaints and grievances share information on the problems they uncover.

2. Uniform Classification System

Another area for collaboration would be the development of a uniform classification of complaints for the purpose of stronger aggregate data on HMO complaints. DMAS has an internal classification that is not congruent with the classification of their enrollment broker to whom the greatest responsibility for recording complaints falls. The process for complaint classification and referral has just begun between BOI and VDH, and the current time would be propitious for the three agencies to pursue a uniform classification system.

3. Complaint Procedure

Theoretically, a Medicaid HMO enrollee who wished to file a complaint could create a great deal

of duplicate effort. The client could complain to the enrollment broker, to the HMO, to DMAS, and to the Bureau of Insurance (from which it might or might not be referred to VDH.) Ensuring a coherent process for Medicaid enrollees should also be pursued by the three agencies.

DATA

I. Medicaid Data Collection Requirements

A. Encounter Data

The Code of Federal Regulations at 42 CFR 434.53 requires a system of periodic medical audits that identifies and collects management data that includes use of services. 1902 (x) of the Social Security Act and the State Medicaid Manual at 2087.8 requires that HMOs maintain sufficient patient encounter data to identify the physician who delivers services and 12 VAC 30-120-380.D. requires that HMOs "report encounter data to DMAS under the contract requirements, which may include data reports based on HEDIS, report cards for clients, and ad hoc quality studies performed by third parties." The DMAS contract for services has very specific requirements for HMO encounter data including HCFA 1500 and UB 92 coding structure. Encounter data is required for services from providers paid under capitation and other risk arrangements, and pharmacy encounter data is required as well. Encounter data is required to be reported quarterly.

B. Other Quality Data

DMAS contract reporting requirements address a number of quality concerns. Sentinel events -- deaths, hospital readmissions, etc.--must be reported within 48 hours of the HMO's knowledge of the event. Changes in provider networks; penalties and sanctions imposed by the SCC or other organizations; deficiencies noted by any accrediting agency; summaries of complaints and grievances; and financial data are reported at prescribed intervals.

Reporting is also required on screenings of high-risk infants and pregnant women, and data is also collected on all live births, stillborn births and spontaneous abortions.

HMOs and their subcontracted providers are required to participate in DMAS QA studies and make medical records available. Two of the quality studies undertaken by DMAS have used large data bases to determine prenatal outcomes and immunization rates. These studies combined DMAS claims and eligibility data with vital statistics and immunization records from the Department of Health.

The EQRO contracted by DMAS developed a data base for elements of medical audit review of sentinel reports. The data base permits profiling by HMO and provider and is thus a very

important tool for quality assessment.

II. Virginia Department of Health

A. Encounter Data Requirements

At this time, submission of encounter-type data is not required of commercial HMOs by BOI or VDH. In 1993 and 1996, the Virginia General Assembly enacted legislation that provided for the creation of a patient level data system under the auspices of a non-profit entity accountable to a Board, the General Assembly, the Governor, and the State Health Commissioner. The purpose of the system is "to establish and administer an integrated system for collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the Commonwealth and to enhance their ability to make effective health care decisions." *(Code*, 32.1-276.6) Recent amendments to the legislation provide for mandatory reporting by hospitals of UB 92's . Also required is that state agencies providing coverage for outpatient services submit patient level data on paid outpatient claims. The data is to include provider, physician, patient, and payor identifiers.(Section 32.1-276.6) Included in the directives to the Board of the non-profit entity are a requirement for the development and administration of a methodology for measuring provider efficiency and productivity; a requirement for a strategic plan that sets forth a recommendation for measuring quality of care for all health care providers; and a requirement to collect, compile, and publish HEDIS reports voluntarily submitted by HMOs.(*Code,* 32.1-276.4*)* While the data from this initiative has had limited use up to this time, the legislation provides for a powerful tool for quality assessment available to the State Health Commissioner.

B. Other Quality Data

The data collected by the Department of Health is extensive and the potential for its use in quality studies is vast. Epidemiological data is collected on immunizations, cancer, trauma, Tuberculosis, HIV, and other reportable diseases. Vital Statistics data has important information on births, deaths, and fetal deaths. Data from the Office of Quality Health Care Services and Consumer Protection includes data on nursing home and hospital beds and utilization. The Office of Family Health Services collects data on services for children with specialty health care needs; data on birth defects; data on dental health for children; nutrition and women's and infants health data; data on primary care for children and adolescents; and family planning data. The Medical Examiners office provides statistical information on cause and manner of death.

The Virginia Department of Health participates in the Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Centers for Disease Control and Prevention (CDC). This program uses a survey to collect information regarding the prevalence of self-reported health problems and behaviors of Virginians and provides data on the risk factors associated with chronic diseases and leading causes of death. The survey is administered to approximately 1800

adult Virginians annually.

III. Areas of Overlap and Potential for Collaboration

Most of the overlapping data collection by DMAS and VDH is data on maternal and child health of indigent populations. The quality studies that DMAS has done on immunizations and prenatal care required data from the health department because of the inadequacy of claims data.

Encounter data, sometimes called "pseudo-claims" or "shadow claims", represents one of the biggest challenges to state Medicaid agencies. There is great difficulty in assuring that encounter data is recorded for all health care visits made by Medicaid clients, and that the data accurately captures all the services received.

In 1996 the Virginia General Assembly mandated an independent evaluation of the first six months of operation of the DMAS mandatory HMO enrollment program, Medallion II. This study found serious deficiencies in the encounter data submitted to DMAS in the first two quarters. The agency has undertaken strenuous efforts to correct the problem, but much of the quality analysis expected to be extracted from encounter data, such as HEDIS measures, will not be possible for the near term.

The possibilities for data sharing pose advantages to both the Department of Health and the Department of Medical Assistance Services as follows:

1. Prenatal and Immunization Studies

DMAS continued use of health department immunization and birth data is recommended until HMO encounter data is proved to be reliable and valid.

2. Sentinel Event Data

DMAS' EQRO will continue to do medical chart review of cases for which a sentinel event has been reported. Because the data base for this project permits profiling of HMOs and providers, the information is of significant potential value for public health purposes. Until the DMAS HMO encounter data is reliable, there is no way for the agency to determine if HMOs are under-reporting sentinel events. The hospital-reported data in the VHI database could be used to determine unreported sentinel events for Medicaid clients and could be used to flag sentinel events for investigation by the health department for commercial HMOs.

3. Maternal, Child, and Adolescent Data

Much of the data collected by the Office of Family Health Services of the Department of Health is potentially useful by HMOs enrolling Medicaid clients, particularly with regard to children's

specialty services. It is assumed that the new Medicaid contract and RFP for the expansion of the Medallion II program will contain more explicit requirements for data reporting on preventive services for pregnant women and children. Collaboration is recommended between DMAS and VDH on use of this data to improve HMOs' ability to effectively serve high-risk pregnant women and infants.

4. Behavioral Risk Factor Surveillance System

DMAS has collaborated with VDH in the development of state-added questions to the BRFSS survey. VDH has the capacity to provide community profiling of health problems and risks. This data could conceivably be used to adjust HMO rate structures to reflect greater need for services in certain areas. It is recommended that the two agencies pursue discussion on incorporating important health risk assessment data into quality improvement programs and explore the feasibility of using the data for other purposes.

5. Standard Setting

The Health Department is the lead agency for implementation of the goals of "Healthy People 2000". The Department has a wealth of national and state-specific data related to this program and to a number of preventable health problems. This data could be used to provide benchmarks of the populations served by Medicaid HMOs in an effort to set performance standards for these HMO's. For example, data on community rates for immunizations could be established as a benchmark, and HMO performance exceeding the benchmark could be rewarded with quality reports cards or possibly rate adjustments. It is recommended that VDH and DMAS consider using data for setting performance standards.

6. Data for Publication to Consumers

The concept of "report cards" has a great deal of appeal to consumers but can be difficult to implement. Adjusting data to account for severity of illness, for example, is problematic. Much of the data sharing that would be useful to VDH and DMAS quality efforts could not appropriately be published or shared with consumers. However, an explicit directive of the study requirement in HB 2785 is to recommend the Commonwealth's role in providing consumer information on managed care issues. DMAS has wanted to be able to publish quality information to assist clients in their choice of HMO's. HEDIS measures for commercial HMOs were published for the first time in the Commonwealth in 1996. Collaboration on data sharing between VDH and DMAS for the purpose of consumer information is a worthwhile objective.

These recommendations only touch superficially on the great potential for improving quality of care to Medicaid clients in HMOs through data sharing. DMAS and VDH have had several meetings on the issue of data sharing, and it is recommended that both agencies inventory the data capabilities they currently have, identify areas where data sharing can have significant impact on quality, examine the barriers to data sharing, such as confidentiality requirements, and

strengthen their quality improvement programs with a comprehensive plan for sharing data.

CHAPTER 688

An Act to amend and reenact §§ 38.2-305, 38.2-4214, 38.2-4308, 38.2-4315 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 4 of Title 32.1 an article numbered 7, consisting of a section numbered 32.1-122.10:01, relating to accident and sickness insurance; health maintenance organizations; contents of policies; State Health Commissioner review.

[H 2785]

Approved March 21, 1997

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-305, 38.2-4214, 38.2-4308, 38.2-4315 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 7, consisting of a section numbered 32.1-122.10:01, as follows:

Article 7.

Review of Health Services Quality.

§32.1-122.10:01. Review of health maintenance organizations.

A. The State Health Commissioner (the "Commissioner") shall examine the quality of health care services of any health maintenance organization ("HMO") licensed in Virginia pursuant to §§38.2-4301 and 38.2-4302 and the providers with whom the organization has contracts, agreements, or other arrangements according to the HMO's health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth. The Commissioner shall consult with HMOs and providers in carrying out his duties under this section.

B. For the purposes of examinations, the Commissioner may review records, take affidavits, and interview the officers and agents of the HMO and the principals of the providers concerning their business.

C. The expenses of examinations by or for the Commissioner under this section shall be assessed against the organization being examined and remitted to the Commissioner.

D. In making his examination, the Commissioner may consider the report of an examination of a foreign HMO certified by the insurance supervisory official, a similar regulatory agency, an independent recognized accrediting organization, or the state health commissioner of another state.

E. The Commissioner also shall: (I) consult with HMOs in the establishment of their complaint systems as provided in § 38.2-4308; (ii) review and analyze HMOs' complaint reports which are required in subsection B of § 38.2-4308; and (iii) assist the State Corporation Commission in examining such complaint systems, as provided in subsection C of § 38.2-4308.

F. The Commissioner shall coordinate the activities undertaken pursuant to this section with the State Corporation Commission to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

§38.2-305. Contents of policies.

A. Each insurance policy or contract shall specify:

1. The names of the parties to the contract;

2. The subject of the insurance;

3. The risks insured against;

4. The time the insurance takes effect and, except in the case of group insurance, title insurance, and insurance written under perpetual policies, the period during which the insurance is to continue;

5. A statement of the premium, except in the case of group insurance and title insurance; and

6. The conditions pertaining to the insurance.

B. Each *new or renewal* insurance policy ~~or~~, contract, *certificate or evidence of coverage issued to a policyholder, covered person or enrollee* shall be accompanied by a notice stating substantially:

"IMPORTANT INFORMATION ~~TO POLICYHOLDERS~~ *REGARDING YOUR INSURANCE*"

"In the event you need to contact someone about this ~~policy~~ *insurance* for any reason please contact your agent. If *no agent was involved in the sale of this insurance, or if* you have additional questions you may contact the insurance company issuing this ~~policy~~ *insurance* at the following address and telephone number [Insert the appropriate address and telephone number, toll free number if available, for the company's home or regional office].

Health maintenance organizations shall add the following: We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia *State Corporation Commission's* Bureau of Insurance at: [Insert the appropriate address, toll free phone number, and phone number for out-of-state calls for the Bureau of Insurance.]

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available."

C. If, under the contract, the exact amount of premiums is determinable only at the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid shall be furnished to any policy-examining bureau having jurisdiction or to the insured upon request.

D. This section shall not apply to surety insurance contracts.

§38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§38.2-1300 et seq.) and 2 (§38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§38.2-4308. Complaint system.

A. Each health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints. The complaint system shall be established after consultation with the State Health Commissioner and approval by the Commission.

B. Each health maintenance organization shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission, after consultation with the State Health Commissioner. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) a compilation of causes underlying the complaints filed, and (iv) the number, amount, and disposition of malpractice claims settled or adjudicated during the year by the health maintenance organization and any of its health care providers. A record of the complaints shall be maintained for the period set forth in §38.2-511.

C. The Commission ~~or~~, *in cooperation with* the State Health Commissioner ~~may~~, *shall* examine the complaint system. *However, at its discretion, the Commission may accept the report of examination conducted by the State Health Commissioner instead of making its own examination.*

§38.2-4315. Examinations.

A. The Commission shall examine the affairs of each health maintenance organization as provided for in §38.2-1317 at least once every five years. The Commission may examine the affairs of providers with whom any health maintenance organization has contracts, agreements, or other arrangements according to its health care plan as often as it considers necessary for the protection of the interests of the people of this Commonwealth.

~~B. The State Health Commissioner may examine the quality of health care services of any health maintenance organization or providers with whom the organization has contracts, agreements, or other arrangements according to its health care plan as often as considered necessary for the protection of the interests of the people of this Commonwealth.~~

~~C. For the purpose of examinations, the State Health Commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.~~

~~D. The expenses of examinations by or for the State Health Commissioner under this section shall be assessed against the organization being examined and remitted to the State Health Commissioner.~~

~~E.~~ B. Instead of making its own examination, the Commission or State Health Commissioner may accept the report of an examination of a foreign health maintenance organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

C. The Commission shall coordinate such examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

§38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§38.2-5300 et seq.) and Chapter 54 (§38.2-5400 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in §38.2-3431, a health maintenance organization providing health care plans pursuant to §38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

2. That the State Health Commissioner, in cooperation with the State Corporation Commission Bureau of Insurance, the Department of Health Professions, and other state agencies as appropriate, be requested to study the quality of health care services provided by health maintenance organizations.

A. The study should (i) examine quality of care mechanisms currently in place for health maintenance organizations (HMOs) and providers with whom they contract, including, but not limited to, state and federal statutes and regulations and review by private accrediting bodies, such as the National Committee for Quality Assurance; (ii) assess the sufficiency of these mechanisms for ensuring quality and providing health care consumers with a means of having their inquiries and complaints addressed; (iii) determine the extent to which such quality of care mechanisms currently exist for forms of managed care other than HMOs (described above) and whether any or all of such mechanisms should be expanded to entities other than HMOs; (iv) examine how the Department of Health and the Bureau of Insurance can coordinate their regulatory roles for ensuring quality of health care services in a manner which minimizes overlapping of authority and duplication of resources; and (v) identify the appropriate role of the Department of Health and any other appropriate state agencies in monitoring quality of care provided through HMOs, other managed care plans, and the providers with whom they contract.

B. The study also should consider whether changes in existing law or regulations are warranted with respect to: (i) the system for investigating and resolving complaints, including whether such system should include complaints by providers and other interested parties on matters which are not purely contractual in nature; (ii) addressing complaints regarding alleged violations of applicable laws or regulations and the manner in which such laws and regulations should be enforced in the Commonwealth; and (iii) whether there is a need in the Commonwealth for a mechanism to be created for the purpose of adjudicating controversies and resolving complaints in connection with alleged violations of applicable law or regulation.

C. The State Health Commissioner also is requested to submit a report by October 1, 1997, to the Governor, the Joint Commission on Health Care and the General Assembly which, in addition to the matters to be reported on as set forth above, (i) recommends the appropriate role of the Commonwealth in monitoring and improving the quality of care in managed care plans which either require or create incentives for covered persons to use health care providers managed, owned, under contract with or

employed by the health carrier; (ii) recommends the Commonwealth's role in providing consumer information on managed care issues; (iii) assesses the licensing functions for individual and institutional health care providers currently performed by the Department of Health Professions and the Department of Health, and determines, in light of current health care market conditions, whether any modification or consolidation of these functions would enhance the Commonwealth's efforts in overseeing the quality of managed care health plans; and (iv) evaluates whether there is a need to establish an external appeals or ombudsman process for resolving consumer complaints regarding managed care plans, and, if so, whether the Department of Health or another entity should administer the process. In formulating his recommendations, the State Health Commissioner is requested to optimize the contributions of other public and private entities such as Virginia Health Information, Inc.'s, role in consumer education, as well as identify other public and private partners able to support these functions.

3. That, in concert with the State Health Commissioner's examination of the quality of health care services provided by health maintenance organizations, the Department of Health be requested to receive and respond to complaints from managed care plan enrollees regarding quality of care issues which are forwarded to the Department by the Bureau of Insurance's consumer complaint review program.

MEMORANDUM OF AGREEMENT
BETWEEN
THE VIRGINIA STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE
AND
THE VIRGINIA DEPARTMENT OF HEALTH
OFFICE OF HEALTH FACILITIES REGULATION

WITNESSETH:

WHEREAS, the Virginia State Corporation Commission (hereinafter “The Commission”), Bureau of Insurance, 1300 East Main Street, Richmond, Virginia 23219 and the Virginia Department of Health (hereinafter "VDH"), Office of Health Facilities Regulation, 3600 West Broad Street, Suite 216, Richmond, Virginia 23230 are desirous of entering into an agreement for the purpose of memorializing the respective responsibilities agreed upon by the parties with regard to the regulation of Health Maintenance Organizations in the Commonwealth of Virginia, and how each party may best assist the other in carrying out such responsibilities; and

WHEREAS, the State Health Commissioner may examine the quality of the health care services of any Health Maintenance Organization or provider licensed by the Commission, as set forth in §38.2-4315 of the Code of Virginia, as amended, and to examine the complaint system of a Health Maintenance Organization as set forth in § 38.2-4308 of the Code of Virginia, as amended; and

WHEREAS, the Commission is authorized to license Health Maintenance Organizations and to suspend or revoke the license of a Health Maintenance Organization pursuant to §§ 38.2-4301 and 4316, respectively, of the Code of Virginia, as amended;

NOW, THEREFORE, THE PARTIES HERETO AGREE TO THE FOLLOWING:

1. The Commission and VDH agree:

   a) The Commission shall be the official “lead” agency contact for the licensure and regulation of Health Maintenance Organizations;

   b) The VDH shall assist the Commission by providing both on-site and administrative review of quality assurance issues relating to Health Maintenance Organizations;

   c) VDH activities conducted under clause 1.b) shall be reimbursed through remittance to the State Health Commissioner by the subject Health Maintenance Organization, upon receipt of assessment invoices, for all actual costs and expenses of the Commissioner's quality of care or quality assurance reviews or investigations both on-site and during administrative review, in accordance with Va. Code §§ 38.1-403, 39.2-4308,38.2-4315, and 38.2-4316;

d) The Commission and VDH shall each bear the costs of its respective responsibilities as agreed upon herein with regard to the regulation of Health Maintenance Organizations in the Commonwealth of Virginia, unless otherwise specifically provided by law; and

e) The VDH and the Commission shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by VDH to the Commission or by the Commission to VDH, and to follow the procedures regarding confidentiality of examination contents and results as prescribed by Article 4, Chapter 13, of Title 38.2 of the Code of Virginia, as amended or as otherwise prescribed by law.

2. The Commission agrees:

a) It will subject any Health Maintenance Organization that fails to reimburse the State Health Commissioner for expenses for quality of care or quality assurance reviews or investigations to any penalties otherwise available to the Commission;

b) It will ensure that necessary documents it receives, such as quality assurance plans and complaints dealing with quality of care, are submitted to the VDH in a timely manner;

c) It will assist the VDH in carrying out its responsibilities in the regulation of Health Maintenance Organizations by providing advice and expertise as requested, including permitting VDH personnel to participate in the Commission's Market Conduct Examinations of Health Maintenance Organizations, as mutually agreed; and

d) It shall effectuate any actions necessary to assure that its licensees comply with quality guidelines.

3. The VDH agrees:

a) It will, in a timely manner during the Commission's review period for initial application for licensure by a Health Maintenance Organization, review and approve Health Maintenance Organization complaint systems, and shall, in a timely manner, review such complaint systems for licensed Health Maintenance Organizations on an annual basis;

b) It will check for licensed providers who are not in compliance with licensure regulations, and who may yet be providing services to Health Maintenance Organizations, and shall report the results of such investigations to the Commission at the time of initial licensure and at such other times as VDH may determine to be appropriate;

c) It will assess the quality of health care services as such quality relates to providers contracting with each Health Maintenance Organization, such assessment to include, but not be limited to, the following:

1. i) A review of quality assurance and utilization review programs as part of the initial licensing process and as needed thereafter. VDH shall advise the Commission of the acceptability of such programs in a timely manner; and

ii) A review of criteria used by the Commission to determine that a Health Maintenance Organization has contracted with the appropriate number and kinds of providers to assure proper access to health care;

d) It will conduct administrative and on-site investigations of consumer and provider complaints regarding Health Maintenance Organization quality of care;

e) It will conduct on-site examinations, in coordination with the Commission, of the quality of health care services of Health Maintenance Organizations, to include:

i) The grievance/complaint system;

ii) Quality assurance plan/goals;

iii) Medical delivery system, including:

Providers
Services
Access
Availability
Organization and Structure

iv) Advertising/Marketing;

f) It will assist the Commission in the revision of regulations upon request; and

g) It will assist the Commission in identifying non-compliant practices in violation of the Code of Virginia, as amended, and any applicable regulations adopted by the Commission.

THIS AGREEMENT shall become effective upon the date subscribed by the last signatory, and shall continue in force until terminated by either of the parties.

Amendments to this Memorandum of Agreement shall become effective upon written approval by both parties.

If any provision of this agreement or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

Date: 1/16/97

By: _____
Alfred W. Gross
Commissioner of Insurance
Bureau of Insurance
Virginia State Corporation Commission

Date: 1-16-97

By: _____
Randolph L. Gordon, M.D., M.P.H.
Commissioner
Virginia Department of Health

SCREENING CRITERIA FOR COMPLAINTS THAT MAY ADDRESS QUALITY OF CARE ISSUES

The VDH will investigate complaints where the quality of the healthcare services provided to enrollees by a health maintenance organization (HMO) licensed in Virginia, or one of its contractors, is in question. The quality of healthcare services provided by a HMO will be reviewed within the context of the enrollee's health plan coverage, mandated benefits, and the laws and regulations governing the provision of healthcare services provided by health maintenance organizations and their providers contained within the Code of Virginia, 1950, as amended, and the Administrative Code of Virginia.

Complaints concerning the quality of healthcare services can generally be applied to the categories that are listed below.

ACCESS TO HEALTHCARE SERVICES

Geographic access limitations to providers and practitioners
Availability of PCPS/ specialists/ behavioral and mental health providers
PCP after-hour access
Access to urgent care and emergency care
Out-of network access
Availability and timeliness of provider appointments and provision of services
Availability of outpatient services within the network (To include HHA, hospice, labs, physical therapy, radiation therapy)
Enrollee provisions to allow transfers to other PCPs
Patient abandonment by PCP
Pharmaceuticals (Based upon patient's condition, the use of generic drugs versus brand name drugs)
Access to preventative care (immunizations, prenatal, STDs, alcohol, cancer, coronary, smoking)
Access to HMO complaint and grievance procedures
HMO enrollee notification regarding changes in the EOB and mandated benefits

UTILIZATION MANAGEMENT

Denial of medically appropriate services covered within the enrollee contract
Limitations on hospital length of stays for stays covered within the enrollee contract
Timeliness of preauthorization reviews based on urgency

Inappropriate setting for care i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
Criteria for experimental care
Unnecessary tests or lack of appropriate diagnostic tests
Denial of specialist referrals allowed within the contract
Denial of emergency room care allowed within the contract
Failure to adequately document and make available to the members reasons for denial
Unexplained death
Denial of care for serious injuries or illnesses, the natural history of which, I untreated, are likely to result in death or to progress to a more severe form
Organ transplant criteria questioned

PRACTITIONERS/PROVIDERS

Appropriateness of diagnosis and/or care
Appropriateness of credentials to treat
Failure to observe professional standards of care, state and or federal regulations governing healthcare quality
Unsanitary physical environment
Failure to observe sterile techniques or universal precautions
Medical records- Failure to keep accurate and legible records, to keep them confidential and to allow patient access
Failure to coordinate care (Example: appropriate discharge planning)

The Center's expectation would be that HMO members had attempted to resolve their complaints initially by accessing the HMOs internal complaint resolution process and for their employers' health benefits office prior to bringing their complaints to the Center unless the complaint was so urgent that it placed the patient or others in serious jeopardy.